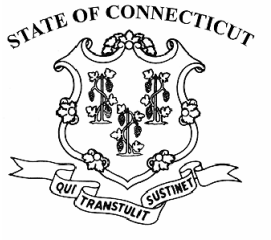

Substitute Senate Bill No. 1214

Public Act No. 07-113

AN ACT CONCERNING POSTCLAIMS UNDERWRITING.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2007*) (a) Unless approval is granted pursuant to subsection (b) of this section, no insurer or health care center may rescind, cancel or limit any policy of insurance, contract, evidence of coverage or certificate that provides coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 of the general statutes on the basis of written information submitted on, with or omitted from an insurance application by the insured if the insurer or health care center failed to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the policy, contract, evidence of coverage or certificate. No insurer or health care center may rescind, cancel or limit any such policy, contract, evidence of coverage or certificate more than two years after the effective date of the policy, contract, evidence of coverage or certificate.

(b) An insurer or health care center shall apply for approval of such rescission, cancellation or limitation by submitting such written information to the Insurance Commissioner on an application in such form as the commissioner prescribes. Such insurer or health care center

shall provide a copy of the application for such approval to the insured or the insured's representative. Not later than seven business days after receipt of the application for such approval, the insured or the insured's representative shall have an opportunity to review such application and respond and submit relevant information to the commissioner with respect to such application. Not later than fifteen business days after the submission of information by the insured or the insured's representative, the commissioner shall issue a written decision on such application. The commissioner may approve such rescission, cancellation or limitation if the commissioner finds that (1) the written information submitted on or with the insurance application was false at the time such application was made and the insured or such insured's representative knew or should have known of the falsity therein, and such submission materially affects the risk or the hazard assumed by the insurer or health care center, or (2) the information omitted from the insurance application was knowingly omitted by the insured or such insured's representative, or the insured or such insured's representative should have known of such omission, and such omission materially affects the risk or the hazard assumed by the insurer or health care center. Such decision shall be mailed to the insured, the insured's representative, if any, and the insurer or health care center.

(c) Notwithstanding the provisions of chapter 54 of the general statutes, any insurer or insured aggrieved by any decision by the commissioner under subsection (b) of this section may, within thirty days after notice of the commissioner's decision is mailed to such insurer and insured, take an appeal therefrom to the superior court for the judicial district of Hartford, which shall be accompanied by a citation to the commissioner to appear before said court. Such citation shall be signed by the same authority, and such appeal shall be returnable at the same time and served and returned in the same manner, as is required in case of a summons in a civil action. Said court

may grant such relief as may be equitable.

(d) The Insurance Commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 2. Section 38a-19 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) Any person or insurer aggrieved by any order or decision of the commissioner made without a hearing may, not later than thirty days after notice of the order to the person or insurer, make written request to the commissioner for a hearing on the order or decision. The commissioner shall hear such party or parties not later than thirty days after receipt of such request and shall give not less than ten days' written notice of the time and place of the hearing. Not later than forty-five days after such hearing, the commissioner shall affirm, reverse or modify his previous order or decision, specifying his reasons therefor. Pending such hearing and decision on such hearing the commissioner may suspend or postpone the effective date of his previous order or decision.

(b) Nothing contained in this section or sections 38a-363 to 38a-388, inclusive, shall require the observance at any hearing of formal rules of pleading or evidence.

(c) The provisions of this section shall not apply to an order or decision of the commissioner made pursuant to section 38a-478n or section 1 of this act.

(d) Any order or decision of the commissioner shall be subject to appeal therefrom in accordance with the provisions of section 4-183.

Sec. 3. Section 38a-476 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) (1) For the purposes of this section, "health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract and does not include (A) short-term health insurance issued on a nonrenewable basis with a duration of six months or less, accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (B) policies of specified disease or limited benefit health insurance, provided that the carrier offering such policies files on or before March first of each year a certification with the Insurance Commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policies in the state; and (iii) in the case of a policy that is described in this subparagraph and that is offered for the first time in this state on or after October 1, 1993, the carrier files with the commissioner the information and statement required in this subparagraph at least thirty days prior to the date such policy is issued or delivered in this state.

(2) "Insurance arrangement" means any "multiple employer welfare arrangement", as defined in Section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, except for any such arrangement which is fully insured within the meaning of Section 514(b)(6) of said act, as amended.

(3) "Preexisting conditions provision" means a policy provision which limits or excludes benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, for which any medical advice, diagnosis, care or treatment was recommended or received before such effective date. Routine follow-up care to determine whether a breast cancer has reoccurred in a person who has been previously determined to be breast cancer free shall not be considered as medical advice, diagnosis, care or treatment for purposes of this section unless evidence of breast cancer is found during or as a result of such follow-up. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information. Pregnancy shall not be considered a preexisting condition.

(4) "Qualifying coverage" means (A) any group health insurance plan, insurance arrangement or self-insured plan, (B) Medicare or Medicaid, or (C) an individual health insurance plan that provides benefits which are actuarially equivalent to or exceeding the benefits provided under the small employer health care plan, as defined in subdivision (12) of section 38a-564, whether issued in this state or any other state.

(5) "Applicable waiting period" means the period of time imposed by the group policyholder or contractholder before an individual is eligible for participating in the group policy or contract.

(b) (1) No group health insurance plan or insurance arrangement may impose a preexisting conditions provision which excludes coverage for a period beyond twelve months following the insured's effective date of coverage. Any preexisting conditions provision may only relate to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during the six months immediately preceding the effective date of coverage.

(2) No individual health insurance plan or insurance arrangement may impose a preexisting conditions provision which excludes coverage beyond twelve months following the insured's effective date of coverage. Any preexisting conditions provision may only relate to conditions, whether physical or mental, **[**which manifest themselves, or**]** for which medical advice, diagnosis or care or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage.

(c) All health insurance plans and insurance arrangements shall provide coverage, under the terms and conditions of their policies or contracts, for the preexisting conditions of any newly insured individual who was previously covered for such preexisting condition under the terms of the individual's preceding qualifying coverage, provided the preceding coverage was continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, except in the case of a newly insured group member whose previous coverage was terminated due to an involuntary loss of employment, the preceding coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, provided such newly insured group member or dependent applies for such succeeding coverage within thirty days of the member's or dependent's initial eligibility.

(d) With respect to a newly insured individual who was previously covered under qualifying coverage, but who was not covered under such qualifying coverage for a preexisting condition, as defined under the new health insurance plan or arrangement, such plan or arrangement shall credit the time such individual was previously covered by qualifying coverage to the exclusion period of the preexisting condition provision, provided the preceding coverage was

continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan, except in the case of a newly insured group member whose preceding coverage was terminated due to an involuntary loss of employment, the preceding coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, provided such newly insured group member or dependent applies for such succeeding coverage within thirty days of the member's or dependent's initial eligibility.

(e) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center which issues in this state group health insurance subject to Section 2701 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from time to time, shall comply with the provisions of said section with respect to such group health insurance, except that the longer period of days specified in subsections (c) and (d) of this section shall apply to the extent excepted from preemption in Section 2723(B)(2)(iii) of said Public Health Service Act.

(f) The provisions of this section shall apply to every health insurance plan or insurance arrangement issued, renewed or continued in this state on or after October 1, 1993. For purposes of this section, the date a plan or arrangement is continued shall be the anniversary date of the issuance of the plan or arrangement. The provisions of subsection (e) of this section shall apply on and after the dates specified in Sections 2747 and 2792 of the Public Health Service Act as set forth in HIPAA.

(g) **[**A**]** Notwithstanding the provisions of subsection (a) of this section, a short-term health insurance policy issued on a nonrenewable basis for six months or less which imposes a preexisting conditions

provision shall **[**not be subject to this section, provided, any policy, application or sales brochure issued for such short-term insurance which imposes a preexisting conditions provision shall disclose that such preexisting conditions are not covered**]** be subject to the following conditions: (1) No such preexisting conditions provision shall exclude coverage beyond twelve months following the insured's effective date of coverage; (2) such preexisting conditions provision may only relate to conditions, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received during the twenty-four months immediately preceding the effective date of coverage; and (3) any policy, application or sales brochure issued for such short-term health insurance policy that imposes such preexisting conditions provision shall disclose in a conspicuous manner in not less than fourteen-point bold face type the following statement:

"THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE TWENTY-FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE."

In the event an insurer or health care center issues two consecutive short-term health insurance policies on a nonrenewable basis for six months or less which imposes a preexisting conditions provision to the same individual, the insurer or health care center shall reduce the preexisting conditions exclusion period in the second policy by the period of time such individual was covered under the first policy. If the same insurer or health care center issues a third or subsequent such short-term health insurance policy to the same individual, such insurer or health care center shall reduce the preexisting conditions exclusion period in the third or subsequent policy by the cumulative time covered under the prior policies. Nothing in this section shall be construed to require such short-term health insurance policy to be

issued on a guaranteed issue or guaranteed renewable basis.

(h) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to enforce the provisions of HIPAA and this section concerning preexisting conditions and portability.

Approved June 11, 2007